



COUNTY OF SAN BERNARDINO
STANDARD PRACTICE

NO 9-2.30

ISSUE

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BY C. Daniels

EFFECTIVE 3/1/94

DEPARTMENT MENTAL HEALTH

SUBJECT WAIVER OF CONSUMER'S
RESPONSIBILITY TO PAY FOR MEDICATIONS

APPROVED

James McReynolds
James McReynolds, Director

(Revised 6/14/94)

I. PURPOSE

To establish standardized policies and procedures for waiving a consumer's responsibility to pay for his/her medication.

II. POLICY

A. A waiver generated by the staff may be approved if the request documents the following:

1. That the consumer cannot function without the prescribed medication.
2. That the patient is experiencing a financial hardship beyond what has been UMDAPPED.

B. The waiver request must include:

1. Type of medication, dosage and cost.
2. A copy of a current or pending therapeutic fee reduction waiver.

C. The prescribed medication must be on the approved LPS formulary list.

III. PROCEDURE

A. Treatment Staff:

1. Treatment staff must complete the "Request to Waive Consumer's Responsibility to Pay for Medications" form (attached) and forward it to the Program Manager, appropriate Deputy Director of Treatment Services and Deputy Director of Medical Services for either approval or disapproval.

B. Program Manager/Deputy Director of Treatment Services/Deputy Director of Medical Services:

1. If either the Program Manager, appropriate Deputy Director of Treatment Services or Deputy Director of Medical Services disapprove, reasons will be stated and the request will be returned to treatment staff.
2. If the Program Manager, appropriate Deputy Director of Treatment Services and Deputy Director of Medical Services approve the request it will be forwarded to the Financial Evaluation Office Manager for processing, with a copy to treatment staff.

C. Financial Evaluation Office Manager:

1. The Financial Evaluation Office Manager will distribute the approved requests to the appropriate Financial Interviewer to make the necessary code change for prescriptions.
2. The approved request will be maintained on file in the family account folder.

D. Duration:

1. Waivers will expire in 90 days.
2. The Financial Evaluation Office will notify the treatment staff person that the waiver has expired and a new waiver request must be submitted, following the same procedure outlined above.

CD:smc

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Cross Reference Pharmacy and Fee for Service Issues 13-3.10.

REQUEST TO WAIVE CONSUMER'S RESPONSIBILITY TO PAY FOR MEDICATIONS

CLINIC NAME: _____

ATE: _____

ACCOUNT NO.: _____

TREATMENT STAFF: _____

CLIENT NO.: _____

CONSUMER NAME: _____

DEDUCTIBLE EXPIRATION DATE: _____

JUSTIFICATION FOR WAIVER:

A.	MEDICATION PRESCRIBED AND DOSAGE	PHARMACY	COST
	_____	_____	_____
	_____	_____	_____

B. NEED FOR MEDICATION: _____

C. FINANCIAL DATA: (Attach monthly expense statement)

CONSUMER'S STATED FAMILY GROSS MONTHLY INCOME: _____

FINANCIAL INTERVIEWER'S STATEMENT ABOUT FAMILY'S GROSS MONTHLY INCOME: _____

NO. OF PERSONS DEPENDENT ON INCOME: _____

IS THERE A CURRENT FEE REDUCTION WAIVER IN EFFECT? _____ DATE: _____

IF NO WAIVER IN EFFECT, WILL ONE BE REQUESTED? _____

D. ADDITIONAL INFORMATION: _____

REVIEWED BY PROGRAM MGR: _____

APPROVED: _____ DATE: _____ SIGNATURE: _____

DISAPPROVED: _____ DATE: _____ SIGNATURE: _____

REASON: _____

REVIEWED BY DEPUTY DIRECTOR, CENTRALIZED/
COMMUNITY TREATMENT SERVICES: _____

APPROVED: _____ DATE: _____

SIGNATURE: _____

DISAPPROVED: _____ DATE: _____

SIGNATURE: _____

REASON: _____

REVIEWED BY DEPUTY DIRECTOR,
MEDICAL SERVICES: _____

APPROVED: _____ DATE: _____

SIGNATURE: _____

DISAPPROVED: _____ DATE: _____

SIGNATURE: _____

REASON: _____

NOTE: THIS FORM, IF APPROVED, IS FOR 90 DAYS. THE EXPIRATION DATE IS: _____